

***Pregnancy Maintenance Initiative
Client Satisfaction Survey***

1. Agency Name: _____
2. Agency City: _____
3. How did you learn about these services?

<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Brochure from agency listed above
<input type="checkbox"/> Pregnancy Care Provider	<input type="checkbox"/> Church
<input type="checkbox"/> Media (television, radio, newspaper)	<input type="checkbox"/> Health Department
<input type="checkbox"/> Adoption Agency	<input type="checkbox"/> Another agency: _____
<input type="checkbox"/> School	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Hospital	
4. Check the services that you received as a result of your participation with the Pregnancy Maintenance Initiative/Case Management.

<input type="checkbox"/> Prenatal Medical Care	<input type="checkbox"/> Adoption Guidance
<input type="checkbox"/> Medical Care (non-pregnancy related)	<input type="checkbox"/> Drug/Alcohol Assessment/Treatment
<input type="checkbox"/> Client <input type="checkbox"/> Infant	<input type="checkbox"/> Domestic Abuse Protection
<input type="checkbox"/> Housing	<input type="checkbox"/> Child Care
<input type="checkbox"/> Alternative Education	<input type="checkbox"/> Parenting Education/Support
<input type="checkbox"/> Paternal Involvement Support	<input type="checkbox"/> Transportation
5. How long did you wait for your first visit with the PMI case manager?

<input type="checkbox"/> less than 1 week	<input type="checkbox"/> 3 weeks
<input type="checkbox"/> 1 week	<input type="checkbox"/> 4 weeks or more
<input type="checkbox"/> 2 weeks	
6. Did you have problems getting to the services (e.g., transportation, appointments conflicted with work schedule or school, child care)?

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Describe the problem: _____

7. Were the days and times for services good for you?

<input type="checkbox"/> No	<input type="checkbox"/> Yes	What days would have been better for you? _____

8. On the average, how long did you have to wait before you were seen by the case manager or other staff at this agency:

<input type="checkbox"/> less than 15 minutes	<input type="checkbox"/> 46 minutes - 1 hour	<input type="checkbox"/> not applicable
<input type="checkbox"/> 15-30 minutes	<input type="checkbox"/> 1-2 hours	
<input type="checkbox"/> 31-45 minutes	<input type="checkbox"/> more than 2 hours	

9. During your visits:
- | | | |
|--|------------------------------|-----------------------------|
| Did the case manager carefully listen to you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did service providers carefully listen to you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel you participated in the goal planning? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Were things explained in a way you could understand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If you checked "no" to any of the above, please explain: _____
-
10. Did you feel you were fully informed of:
- | | | |
|--|------------------------------|-----------------------------|
| Available services to continue your pregnancy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Location of services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Requirements of services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Length of services during pregnancy and after? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
11. If these services had been unavailable, what would you have done in relation to your pregnancy and other needs?
- _____
- _____
- _____
12. Would you recommend these services to a friend or relative? ☐ Yes ☐ No
13. How old are you?
- | | | | | |
|-----------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> under 15 | <input type="checkbox"/> 15-17 | <input type="checkbox"/> 18-19 | <input type="checkbox"/> 20-24 | <input type="checkbox"/> 25-29 |
| <input type="checkbox"/> 30-34 | <input type="checkbox"/> 35-39 | <input type="checkbox"/> 40-44 | <input type="checkbox"/> 45-54 | <input type="checkbox"/> 55 or older |
14. What is your race?
- | | | |
|--------------------------------|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Other |
15. Do you consider yourself to be of Hispanic origin? ☐ Yes ☐ No